Millfield James Limited

7 Eworth Close

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This is the first inspection for 7 Eworth Close since the changes in registered provider. This service offers accommodation and personal care to six people with learning disabilities.

The manager in post had applied for registration with us and the process was in progress. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider information return submitted on 28 October 2015 stated "each person has a Person Centred Plan (PCP) that they complete, along with their Key Worker and other staff. The PCP has details about them that they wish to share including their likes, dislikes, wants, wishes and aspirations." The manager had also identified PCP as an area for improvement over a 12 month period. However, the four PCP files we reviewed were incomplete which showed little improvements had taken place. The photographs and "all about me" information were not drawn together into a plan which gave staff guidance on how to deliver care in the persons preferred manner. For example, their routines and how to help people achieve their goals.

Care plans lacked detail and did not centre on the person. Staff lacked an understanding of person centred care. People were not involved in the planning of their care and their preferred routines, their likes and dislikes and life stories were not gathered. This meant people's care and treatment was not delivered in people's preferred manner. House rules were rigid and did not give people an opportunity to have control over their care and treatment. For example, there was little flexibility with meal times, where people were able to eat their meals and visitors.

Members of staff knew how to minimise the risk to people but risk assessments were not respectful to people's rights. Action plans were not always clear on how staff were to minimise the risk or to enable people to take risks safely.

People's capacity to make specific decisions was not assessed. For example, people were not given access to some records and did not to participate in the development of their behaviour management plans. The decision not to give people access to records was made despite people being present while their behaviour was discussed at review meetings arranged by their care manager.

Some people at times presented with behaviours others found difficult. Members of staff described the actions they took to prevent the situation from escalating. People's capacity to be part of the development of their behaviour management plans was not assessed. The plans in place were not person centred and people were not valued as an individual. For example, staff were to sign "bad" to a person although in bracket it was stated the behaviour was "bad" not the person. Health and social care professionals provided guidance on managing situations for one person in a person centred manner but the guidance was not used

to develop a care plan. This meant the staff were not working within the principles of the Mental Capacity Act (MCA) 2005 as decisions were not made in the person's best interest and in the least restrictive manner.

With the exception of one person, people were subject to continuous supervision in the community. People were accompanied by staff in the community but Deprivation of Liberty Safeguards (DoLS) application to the supervisory body were not made. This meant there was a lack of understanding of the MCA principles.

People's rights were not always respected. Records showed the terminology used by staff was patronising to people. There was a strong emphasis on diet and there was a lack of choice given to people on weight management plans. People were not assisted to have privacy in some of their relationships. Visits had to take place in the lounge with others present.

People said they felt safe living in the home and the staff made them feel secure. Members of staff knew the types of abuse and the responsibility placed on them to report suspicions of abuse to the manager.

Medicine systems were safe and staff administered medicines to people.

We saw good interactions between people and staff. People said staff cared for them well. Some people said they would approach the staff if they were "not happy about something". Other people said they would discuss their concerns with their parents.

Staff attended the training set as essential by the provider which included safeguarding of vulnerable adults, first aid and MCA. One to one meetings between the staff and the manager to discuss issues and training had taken place.

People's views were gathered during house meetings and some of their suggestions were acted upon. Staff said they worked well together and staff meetings took place were their suggestions were recorded by the manager.

Quality assurance systems were in place and audits were undertaken to assess the quality of people's safety and wellbeing.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risks were assessed but action plans on minimising the risk and for people to take risks safely were not developed.

Safe systems of medicine management were in place. Staff signed medication administration charts to show they had administered the medicines. Protocols were developed for administering homely remedies for minor ailments.

Sufficient levels of staff were deployed to meet people's needs.

Staff knew the procedures they must follow if there were any allegations of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were assisted by staff to make some day to day decisions. People's capacity to make specific decisions was not always assessed. Members of staff showed a lack of understanding of the principles of the Mental Capacity Act (MCA) 2005.

Deprivation of Liberty Safeguards (DoLS) applications were not made for people subject to continuous supervision.

Members of staff attended mandatory training set by the provider and other specific training to support people's changing needs. Staff had one to one meetings with the manager.

Is the service caring?

Requires Improvement

The service was not always caring.

People's care plans did not specify how people wanted their care and support to be provided. People's rights were not always respected.

The interactions we observed between people and staff were positive.

Is the service responsive?

Requires Improvement

The service was not consistently effective.

Care plans were not developed and lacked detail on how to meet people's needs. People were not at the centre of their care and treatment.

People were assisted to participate in community and in house activities.

No complaints were received from relatives and members of the public since the last inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems to monitor and assess the quality of care were in place. These systems were not effective as findings of this inspection visit were not identified as areas for improvement on the monthly visits by the provider. This meant not all areas assessed had been identified as needing improvement.

Members of staff worked well together. Members of staff lacked an understanding of the person centred approach to meeting people's needs

Systems were in place to gather people's views

7 Eworth Close

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 12 February 2016 and was unannounced.

The inspection was completed by one inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.' We also reviewed information we hold about the service, including notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with one person on their own, another person with their relatives and two people with staff present. We also spoke to three staff, the manager, the proprietor and the Operations Manager. We contacted local authority commissioners and trainers from Swindon Borough Council. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service.

Requires Improvement

Is the service safe?

Our findings

Risks were assessed but lacked detail on how staff were to minimise the risk or support people to take risks safely. Staff were aware of the actions needed to minimise risks to people's health and wellbeing. However, risk assessment action plans were not developed from all the information gathered. For example, a risk assessment was developed for "bullying" behaviour which stated "XX is known to bully and intimidate other people" when "staff are not in the vicinity." The probable and possible effects were listed for example, it is highly probable the behaviour will upset others and it is possible other [people] may retaliate. This meant a structure was not in place for staff to follow on minimising risks identified.

The manager responded to our feedback and stated "Having spoken with staff regarding their understanding of the risk assessment and actions to take in hope of reducing the risks, they have confirmed that they understand all actions to be taken. Staff have confirmed that they feel able to ask for clarification (and indeed have done so in the past) if there is anything they are unsure of. Staff working with the people they supported knew each individual well and so the information given in the risk assessments are clear to them."

Staff reported any incidents and accidents. We saw recorded where people had made allegations that other people were "pushing and hitting" them. The incidents were investigated and people retracted and moderated their comments. The manager said based on the investigation the incidents were not referred for safeguarding of vulnerable adults. This meant the manager had not followed safeguarding adult's procedures by referring all allegations abuse to the local authority for investigation.

People said they felt safe at the service and relatives told us they had no concerns about their family member's safety. Members of staff knew the types of abuse and the actions they must take for suspected abuse. They said it was their responsibility to pass allegations of abuse to the manager. Safeguarding adults procedures were on display in the office which listed the contact details of the statutory body for referrals of alleged abuse.

People said they knew the staff. Relatives said the staff were good however, more staff to provide activities would be "good". Two staff were on duty on the days of our visit. Staff said one member of staff worked a 24 hour shift and there were two other shifts which covered 9am-5pm usually worked by the manager or deputy and a 4-8pm.

Systems of medicine management in place were safe. People said the staff administered their medicines. One person said if they had a headache the staff would administer pain relief. Medicine administration records (MAR) charts were signed by the staff to indicate they administered the medicine. Medicine care plans stated the person was unable to self-administer their medicines but the way this decision was reached was not detailed in the support plan. The manager provided additional evidence that one person has been self –administering mouthwash for several years

GP's were consulted on the homely remedies people were able to have for minor ailments. Each person had

a profile of homely remedies that staff could administer for ailments such as cough mixture and pain relief. The purpose of the medicine, the maximum dose to be administered in 48 hours and the directions for administration was included in the profile.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People were helped to make some decisions. One person said the staff helped them with finances because they were not good with money. Another person said they made daily decisions. A relative seeking power of attorney for care and treatment said their family member was able to make day to day living decisions.

Staff were knowledgeable about the daily decisions people were able to make for themselves. For example, people were able to budget for their toiletries and activities. Staff comments about people making decisions included, "what people eat and where they go is done in their best interest". A member of staff said some people refused health checks and their medicines but were not forced. For example, they cancelled and rescheduled a dentist appointment when one person refused to keep their appointment.

There was a lack of understanding on how staff were to help people make informed choices about their care and treatment. Where there was concern about people making healthy eating choices their capacity to make these decisions was not assessed. Staff were making decisions about people without following the principles of the MCA. For example, we saw recorded in the dairy for 4 January 2016 "XX had a treat at "open door" today and after dinner asked the staff for a treat knowing she already had a treat. [Staff name] explained she will not have her treat tomorrow she accepted this." Another entry for the same person dated 19 January 2016 stated "staff picked XX from "open door" and XX said they had treats today. They had birthday cake today. When staff asked XX if she had cake she said she didn't. Staff said they would ask." This meant people were subject to restrictions not authorised in line with the principles of the Mental Capacity Act 2005 (MCA).

The care plans in place to help people make informed decisions lacked detail. The specific decisions people could make were not described in the care plans. People's capacity to make decisions was not assessed and action plans lacked guidance to staff on how the person was to be assisted. For example, the support plan stated the objective was for the person to make informed choices. The action plans, however, lacked clarity on options to be offered or how to check the person understood the choices available to them. For example, the instructions such as repeating the options but not included were the types of options staff were to offer. For example, the instructions such as repeating the options but not included were the types of options staff were to offer, give the person time to reach a decision but the decision to be made was not included and to praise them were recorded.

People did not have access to all their documents. One person said "some bits I can read." (of the care

plan).However, peoples capacity to make decisions about their care records was not assessed and decisions to restrict access to their records were not made in their best interest and did not follow MCA principles. It was recorded for one person "due to the level of anxiety that XX experiences around her behaviour and care not all documents will be read and signed by XX to ensure that she is not upset. Also recorded was that this person required support in the community at all times because of "their behaviour". For another person we saw a document signed by the manager dated 5 October 2015 which stated "Due to the nature of XX mental health. It has been agreed by the team at Eworth and psychiatrist that XX will not read and sign all the appropriate documentation in her file. In the past reading some of the documents about her behaviour have been known to upset her. XX and I have read through some care plans and risk assessments others have not been read to her as it is believed it may trigger negative thoughts and cause major anxieties and behaviours". For a third person we saw recorded "due to XX level of comprehension he is not able to understand the contents of his service user profile he is therefore not asked to sign. He has also not shown a wish to listen to them. MCA assessments for the decisions reached were not made following MCA principles and records of best interest decisions were not in place. This meant the decisions reached not to give access to records had not followed the best interest principles of the MCA 2005.

We noted that people were present at their reviews where their behaviours were discussed with their care manager (social worker). Following the meeting a copy of their care plan review was sent to the home for the manager to distribute. However, the manager stated in their email response to our written feedback that "some documents have not been read to them for fear that it may cause them distress; this has been the case in the past. This was discussed with the Eworth Team and in the case of one person this was agreed to with psychiatrist. If either individual requested to see these documents they would, of course, have access to them."

Two people told us they could at times become frustrated or what they described as "moody". One person said the staff asked them to go to their bedrooms to calm down. Another person said they were prescribed with medicines for their "moodiness". A third person said there was another person living at the service who at times shouted and the staff "sent him to his bedroom.

Staff said there were people who at times presented with behaviours others found difficult to manage or to observe. Staff said risk assessments and guidelines for behaviours that challenge were in place and stated "keeping calm and getting to a place where discussion can happen" was the approach used. Staff said they had received training on managing challenging behaviour and they were told "never restrain. Verbalise to diffuse the situation." The challenging behaviour guidelines for people who at times exhibited behaviours others found difficult were restrictive to people. There was little evidence that people had agreed to these strategies. For example, we saw challenging behaviour guidelines for one person stated "when XX asks for something she is unable to have such as going out or sweets staff will explain calmly why it can't happen. When asks again explain again and if this continues staff were to state XX I am not taking about it anymore. Make yourself busy [staff] so that XX does not feel she has distracted you"

The guidelines for another person stated they found it difficult to be calm and said "nasty things" and that they were "rude" to others and staff. It was stated "if XX behaviour has not been good and asks to go out later in the day or the next day staff will tell her she can talk to staff about it later or when she gets up the following day. If staff feel that she is calm enough to be safe later or the following day she will be able to go out if there is time. If there is not enough time then do a nice activity at the home. The guidelines stated that "this is not a punishment but a way to keep XX and staff safe." Staff said if the person's behaviour in the community was inappropriate for example, using foul language, a visit with their "boyfriend" would be missed. They said guidance would be sought from the manager, any action would be the last resort and the visit would be organised for the following week. However, applications were not made to the supervisory

body under DoLS procedures and in line with the principles of the MCA. This meant the sanctions imposed restricted people and were unauthorised.

Deprivation of Liberty Safeguards (DoLS) applications to the supervisory body for continuous supervision were not made for people subject to supervision in the community. A member of staff said one person was able to access the community without staff support but other people living at the home needed to be supervised. When we asked one person if they were able to leave the home on their own they said the manager "won't let me out on my own. I am not trusted but I am happy with the staff."

The manager told us there was a DoLS application made to the supervisory body for one person for health care tests. The manager stated in the email response to the written feedback given at the end of the inspection that "capacity assessments have been carried out for two people regarding their dietary needs and for three people regarding finances." They said a request to the local authority "regarding individual's ability to consent to living at 7 Eworth Close with a view to requesting DoLS applications where required, however, these have not yet been completed." While input from the local authority for best interest decisions was requested for one person with dietary needs and DoLS for finance, applications were not submitted for continuous supervision for the people at the home. This meant legal authority under the MCA was not in place to deprive people of their liberty.

Where people had capacity to make decisions they were not part of the discussion about their behaviour management plans. This meant behaviour plans were not in place on how staff were to support the person when inappropriate behaviours were presented.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care and treatment from staff that were skilled and well supported. Staff said they had an induction when they started at the home. A member of staff said they had shadow shifts with experienced staff to get an idea of the home's routines and people who live at the service.

Essential training set by the provider was available to the staff. Staff said they were able to access first aid, food hygiene and safeguarding adults training. They said there was refresher training. Relatives said "some staff" had the skills needed to meet their family member's needs. We looked at the training records of staff and saw that they had attended first aid, food hygiene, Health and Safety, Epilepsy awareness, safeguarding from vulnerable adults and MCA 2005 training.

Staff said and records confirmed that one to one meetings with the manager were organised and at the meetings people's care and support needs and staff training was discussed.

People told us they had enough to eat. Menus were developed by the manager. Staff said people were asked about their likes and dislikes and this information was kept in the kitchen and used to develop menus. They said "we stick to the menus" but if people refuse the meal an alternative was served. One person said they had an alternative to eat when beef stew was on the menu. Another person said they made refreshments when they wanted. The third person said the menus were on display in the kitchen.

The menus in place showed people had cereals or toast for breakfast, a light lunch and the main meals in the evening. People said staff prepared the meals and they were able to make their own refreshments. We saw that the fridge in the kitchen had milk for people to make their own refreshments and some fresh vegetables. Fridges, freezers and the majority of food stores were kept in the garage which people were not

able to access without staff support.

On the first day of our inspection we found in a base cabinet in the kitchen unlabelled freezer bags with cereals. On the second day we found dated sealable bags with cereals. People confirmed they had a cereal bag for their breakfast. When we asked if people could have more than one bag of cereal for breakfast or toast if they were still hungry they said "no". The manager said the cereal was decanted into bags for portion control. However, the bags did not have the same amount of cereals and people were not aware of the cereals they were eating.

The mealtimes were breakfast from 7am and alongside in brackets it was stated "you will usually need to have eaten breakfast by 10am, lunch was 12pm – 2pm, dinner was 5pm - 6:30pm and for supper it was stated "you need to have eaten supper by 9:30pm so that the kitchen is clean and tidy by 10pm.

When we asked people they confirmed if they were late for breakfast they had to wait until lunchtime. They said the staff encouraged people to rise before 10 am. Staff confirmed that people were to have their breakfast before 10:30am and after 10pm the kitchen was locked. They said people were discouraged from eating after 10pm but if staff were awake when people asked for refreshments then it would be provided. Staff said biscuits, puddings and desserts were not served and confirmed people were able to have fruit. Staff's comments included "there is always fruit to graze on. [It's] for their health. [I] wouldn't refuse [if people asked for their treat boxes] I would offer an alternative and distract them" and "we encourage XX to limit their intake of treats."

Each person was able to purchase "treats" (sweets and chocolates) that were kept in individually labelled boxes in the kitchen. People were able to have a treat from their boxes at 6:30 pm with a drink. One person said they had "sugar intolerance" and was able to have a "treat" each day. Staff said "we encourage [people] to have their supper at 6:30pm it's their treat." Applications were not made to the supervisory body under DoLS procedures and in line with the principles of the MCA. This meant the sanctions imposed restricted people and were unauthorised

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported with their ongoing health care needs. They said the staff usually made appointments when signs of deterioration in health were exhibited. Health action plans in place helped people to maintain good health. These records confirmed a variety of local health professionals supported people including dentist and specialist consultants.

Requires Improvement

Is the service caring?

Our findings

Despite people telling us their care was delivered in the way they liked they were not supported to develop their own care plans on their preferred routines and to set goal about their future. people were not supported to develop their own care plans on their preferred routines and to set goal about their future. Person centred plans were not developed on people's preferred routines, likes and dislikes and life stories. This meant people were not always valued and respected as an individual and were not supported to live their life in the way they wanted.

People were supported to maintain contact with relatives. People said their relatives were able to enter their bedrooms. Some people were in relationships. They were able to visit and have visits from their partners. Their comments included "I see my boyfriend at his house. We got engaged at Christmas. He visits in the lounge" and "yes I have missed visits," "staff told me I can't have a boyfriend in my bedroom. He has to learn he must stay in the lounge. The manager says you can't go in your room. The manager does not trust me; I say I am doing nothing." The minutes of the house meeting on 9 February 2016 included the feedback from one person. It was recorded that one person stated "if they wanted to cuddle up together it would be better to do it in their bedrooms so that people's feeling were respected." This meant people were subject to restrictions not authorised in line with the principles of the Mental Capacity Act 2005 (MCA). People's rights were not respected and dignified care and support was not provided.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded to our feedback and stated "During each House Meeting each person supported is asked if they are happy with/would like to say anything specific about the House or the Staff. They are given the opportunity to talk about any other issues they have." It was also stated that "People's needs and preferences are also discussed during their annual review; again this is taken into account when developing Care Plans."

Some people said they did not have keys to their bedrooms but staff knocked before they entered their bedrooms. One person said "when you are in your room you can do what you want." Staff gave us examples on how they respected people's privacy and dignity. They said people were able to lock their bedrooms when they were out and staff knocked on bedroom doors and waited for an invitation to enter.

People said the staff cared for them. One person said "The staff care about me and they worry about me." A member of staff said good communication and listening to people ensured they knew the "things people enjoyed". They said some people were not able to "articulate if they don't like an activity for example, and staff picked up on their body language". Another member of staff said relationships with people evolve over time, they spent time getting to know people's interests.

Requires Improvement

Is the service responsive?

Our findings

People knew records were kept about them in the office. Staff said there were care plans and guidelines on people's preferences which detailed people's opportunities to experience activities. They said the manager produced the care plans and staff were expected to read them and to sign the document to indicate they had read them. A relative told us they were invited to care plan review meetings by their family member's care coordinator.

The provider information return submitted on 28 October 2015 stated "each person has a Person Centred Plan (PCP) that they complete, along with their Key Worker and other staff. The PCP has details about them that they wish to share including their likes, dislikes, wants, wishes and aspirations." The manager had also identified PCP as an area for improvement over a 12 month period. However, the four person centred files we reviewed were incomplete. The photographs and "all about me" information was not drawn together into a plan which gave staff guidance on how to deliver care in the persons preferred manner. For example, their routines and how to help people achieve their goals.

The four person centred files we saw we were incomplete. The photographs and "all about me" information was not drawn together into a plan which gave staff guidance on how to people were to be supported. For example, their routines and how to help people achieve their goals.

Care plans were not centred on people as an individual. For example, there was no evidence people were involved in developing action plans on how the staff were to assist them. The care plan for one person not at risk of choking stated "if XX insists on rushing his food and is not responding to staff, then staff are to gesture tell him to put his knife and fork down between meals. If XX insists staff are to put their hands above the food repeating requests to wait." For another person their preference and daily routine was not part of their personal care plan. It stated "XX will be woken up in the morning. XX will be left in the wet room for a short period." For another person the objective of the support plan was to create continence routine as the person had continence needs and it was recorded "spend an inappropriate amount of time using the toilet." The guidelines to staff were for staff to carry out personal care checks at regular intervals and in bold writing the immediate action to be taken should personal care be needed.

Routines were rigid and inflexible and people were had not agreed to them. It could not be confirmed that these were in the person's best interest.

Behaviour support plans focused on the negative aspect of the behaviour. Decisions on how to respond to the person were not made in the person's best interest. For example, we saw in one care plan that the aim "was to manage behaviour in an appropriate way". The action plans described the behaviour the person may present when they became "frustrated/angry" which included "to throw items, scream or hit out at people (usually staff)"and staff were to identify the cause of the person's anger or frustration. However, how they were to investigate the potential causes of the behaviour was not included. When the person then threw objects staff were directed to "sign bad" and in brackets it stated "never tell XX he is bad or that he is a bad man-it is the behaviour that is bad." Staff were also instructed not to encourage the person to

participate in the cleaning up process because "It has been observed that XX is happy to "clean" up any mess that he has made. It is believed that he understands that he will get more attention through one to one support to clean this up. XX is to be asked to leave the room." This meant the person's need for interactions and how it could be provided in a positive way by the staff was not considered

Terminology used by the staff in communications books were not always respectful. We saw recorded where staff had used words such as "reprimand" and that "XX was showing off but failed!" The manager said "reprimanded" was better that "told off".

Staff said when shift changes occurred there was handover of information about people. A handover sheet was used to give a brief description of people wellbeing and referred staff to read individual diaries for more detailed information. This ensured staff were aware of people's changes

House rules and regimes did not always give people choice and control over their preferences and were restrictive. Copies of house rules were kept in people's care records. House rules were updated on 5 November 2015 and focused on mealtimes and where meals were eaten, visitors and restricted areas. We saw a copy of the house rules dated 2012 in one person's bedroom and it acknowledged if people were to rise after 10am then they missed breakfast. For another person we found a copy of the house rules in their care file which stated "staff will support you to follow healthy diet and to eat regular intervals (for example not eating breakfast so late that it is lunch time straight away). We noted for one person healthcare input had been sought about the management of their weight.

Staff confirmed people had to have their breakfast before 10:30am and they encouraged people to be up before then to have their breakfast. Staff said "people miss breakfast if they come after 10:30am. For example, one person will pull the duvet over them and say they do not want to get up. I prompt XX to get ready." For another person staff said "we prompt three times [for meals]. Other comments made by staff included "guidelines for routines were in place and they were not previously questioned but would not adhere to these rules." Meals had to be eaten in the lounge or dining room. One person would eat in his room. Another member of staff said "there is a good reason to have a routine for their health and safety. They have to live as a group there are practicalities". The manager said the house rules were to be discussed at the next house meeting. People's comments about the house rules included "Can't go into the garage. It is dangerous and staff must be there. This person was aware of respecting issues around confidentiality and told us "I can't barge into the office I need staff permission. I can't go into the office. I wait outside." This routines and house rules did not reflect people's individuals needs and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said there were house meetings where people could discuss activities. People told us they were allocated days to clean their bedrooms. They told us the staff helped them to clean their bedroom. One person said they participated in meal preparation and cleaned their bedroom. Staff said "people will usually participate in room cleaning. When people refuse another day is suggested". It was explained "it is one to one time with the keyworker [member of staff designated to work with specific people]. It's an opportunity to chat with people." The weekly activities rota showed people had one day allocated to cleaning their bedrooms and on the other days they participated community activities such as trampolining, gym, day care services and went on shopping trips. Another person told us they were able to travel independently to their day care service.

We saw the complaints procedure was in pictures and words. We saw a copy in the office and in one

person's bedroom. Staff said if people raised concerns they would make every effort to resolve their complaints. The manager said there were no complaints received since the last inspection. Some people said they would approach the staff if they were not happy.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance arrangements were in place to assess people's safety and well-being. Audits were in place and included cleaning schedules and medicine audits. Cleaning schedules detailed the tasks to be undertaken and when the task was complete the schedule was signed by the staff that completed the task. Staff completed a checklist to show the medicine checks undertaken.

Arrangements were in place for monthly visits to be undertaken on behalf of the provider. We looked at the most recent visit which occurred on 1 February 2016. The report from this visit included the systems checked For example, "each person had a person centred care plan and a series of risk assessments."

The provider information return submitted on 28 October 2015 stated that over 12 months "Person Centred Plan has been developed and will be completed with each Service User; this will allow them to show what they have achieved over past years. They will also be able to make plans for the short, medium and long term. Key workers will work with individuals to ensure that the Person Centred Plan is personal to them.

The four person centred files we reviewed were incomplete. The photographs and "all about me" information was not drawn together into a plan which gave staff guidance on how to deliver care in the persons preferred manner, their routines and how to help people achieve their goals. We found improvements had not taken place as the person centred files were incomplete for some people and for others all section of the file were not completed. The audit systems in place were not effective as the findings of this inspection visit had not identified as area for continuous improvement on the February visits by the provider.

There was a lack of understanding of person centred approach. We saw on display in the notice board in the office two documents dated 23 January 2016. One document was written in print by the manager which said "I know I must not stand on chairs in my bedroom for any reason. Chairs are for sitting on only. This is to keep me safe." The name of the person and the manager was in print at the end of the document. The person then copied the text into a second document which the person, the manager and the keyworker signed. The manager said the person had asked to have an agreement and they had fulfilled this request.

The views of people were gathered. People told us there were house meeting. One person said "we sit around the table" and talk. Relatives we spoke with said they knew the manager and were able to discuss issues as they arose.

The manager in post was in the process of registering with us as the manager of the service. The manager said the vision and value were to provide everyone with opportunities to experience things. For example, one person wants to experience extreme trampolining." They said the approach was person centred that people had to "have opportunities and choices."

Staff said the team worked well together. They said team meetings were held to discuss issues and their suggestions were "documented". The staff we spoke with said the approach was "good care and good

practice and a safe environment for people. People have opportunities for a good life and experiences. There was an element of making decisions." Another member of staff said the approach was person centred they stated "as best as possible people are individuals. We have different approached. We have to be mindful and aware." The manager said their style of management was approachable and that they had an inclusive style of management. They said there were discussions before an action was taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans lacked detail and people were not at the centre of their care. People's likes and disliked and there preferred routines were not gathered to develop person centred care plans. Staff lacked an understanding of person centred approach to care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People had little autonomy and their care plans were not developed in a manner that respected their rights.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make specific decisions was not assessed. Best interest decisions were not made and the least restrictive option used. Some people were subject to continuous supervision in the community but Deprivation of Liberty Safeguards (DoLS) application were not made to the supervisory body.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

Safeguarding adults procedures were not always followed. Referrals were not made to the local authority for people who alleged physical abuse by other people living in the home.

Control measures were imposed on people as they were not able to make decisions about when they were able to have food items they purchased for themselves.